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The Misdiagnosis of "Depression"

SUMMARY

The author employs recent diagnostic criteria to distinguish between depressive illness (major depressive episode) and other conditions involving depressive mood that more commonly present to the family physician. Relative indications for antidepressant medication and for two types of psychotherapy are discussed. The potential results of routinely prescribing antidepressants to patients who complain of depressive mood are outlined. (*Can Fam Physician* 1989; 35:1105–1107.)

RÉSUMÉ

L'auteur se sert de critères diagnostiques récents pour différencier la maladie dépressive (épisode dépressif majeur) des autres conditions impliquant une humeur dépressive auxquelles les médecins de famille sont souvent confrontés. Les indications relatives concernant la médication antidépressive et deux types de psychothérapie y sont discutées. L'article décrit les conséquences potentielles de la prescription systématique d'antidépresseurs aux patients qui se plaignent d'humeur dépressive.

Key words: depression, diagnosis, misdiagnosis, antidepressants

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THE COMPLAINT of "depression" is a common presenting symptom in the family physician's office, especially if one includes vague somatic complaints such as fatigue, dizziness, and malaise for which a medical diagnosis often cannot be made.[1] Overall, however, the incidence of depressive affective disorder is relatively low.[2] This low incidence can be explained by the fact that the criteria for depressive illness ("major depressive episode") permit physicians to make this diagnosis only in cases of relatively prolonged and severe depression in which vegetative signs of depression are usually prominent.[3] The restrictive nature of this diagnosis is useful in that the diagnosis implies the need for biological treatments such as antidepressant medication and electroconvulsive therapy. Given this management of the condition, the prognosis is relatively good.

On the other hand, conditions such as dysthymia and adjustment disorder with depressed mood are less responsive to these treatments. The frequency of presentation of these conditions in a family physician's practice is, in my experience both as a consulting psychiatrist and as an instructor in a family-medicine residency training program, much higher than that of major depressive episode. Nevertheless, I have observed that antidepressant medication is quite regularly prescribed for patients complaining of depressive mood, regardless of whether the patients have symptoms suggesting that their "depression" would be responsive to antidepressants.

Perhaps this tendency to prescribe antidepressants has had the beneficial result of lowering the incidence of severe depressive illness in the community. However, the price that many of our patients pay to achieve this result is that they are often given a treatment that offers little hope of relieving their complaints; that involves potentially dangerous side-effects, such as cardiotoxicity and other anticholinergic symptoms; and that is dangerous in overdose. In addition, physicians may prescribe some antidepressants that "satisfy" both themselves and their patients while with-

holding a treatment that may offer a better chance of helping the patient.

Major Depressive Episode

Major depressive episode is relatively easy to diagnose. Features include significant, persistent, and prolonged dysphoric mood ("blues"); feelings of guilt and self-reproach; difficulty in concentrating; thoughts of death; and psychomotor retardation or agitation. Vegetative signs of depression include early morning wakening; loss of weight, appetite, pleasure, and energy; and loss of interest in sex and in the patient's usual interests and activities. Other vegetative signs are constipation and a diurnal variation in mood, feeling worse in the morning and better later in the day. Rarely the practitioner will see a patient with a psychotic depression, with mood-congruent delusions (of guilt or impoverishment, for example) or hallucinations (such as accusatory auditory hallucinations).[4]

A reliable diagnostic sign is that the depression has become "autonolous": that is, the depression has taken over and is the main preoccupation of the patient, whose social and occupational functioning is impaired. The depressive mood of these patients is persistent, as distinct from patients with dysthymia or with adjustment disorder with depressed mood. Patients in this last group can often be distracted from their depressed mood, or can find some temporary relief and improved functioning in taking activity. Many, if not most, patients with major depressive episode warrant admission to a psychiatric unit because of their increased suicide risk. Such a setting can also provide the necessary support to them that cannot be provided on an out-patient basis.

"Non-Major" Depression

The diagnosis of adjustment disorder with depressed mood is appropriate when a patient experiences depressive mood following a psychosocial precipitant. Such a precipitant is often a disappointment or loss in a relationship, or some other blow to the patient's self-esteem. The patient is acutely miserable, and will often present in a "crisis" shortly after the precipitant has occurred. By definition, the depressive symptoms are not severe enough to warrant a diagnosis of major depressive episode. A careful history may elicit not only the precipitant of this disorder but also earlier disappointments in relationships that make the current reaction more understandable. The term "reactive depression" has been used in the past to describe similar conditions.

Antidepressant medication is almost never indicated for non-major depression. What is indicated is an ongoing attempt on the part of the physician to support the patient through the crisis and to help the patient find a solution to his or her problem.[5] If the patient's symptoms become unsupportable on an out-patient basis — if, for instance, he becomes suicidal or severely agitated or more severely depressed — consultation with a psychiatrist or admission to a psychiatric unit may be appropriate.

The diagnosis of dysthymia is appropriate when a patient experiences prolonged, if fluctuating, depressive mood for a period of at least two years that is, again, not severe enough to warrant a diagnosis of major depressive episode. These patients are chronically miserable, and usually a personality disorder can be concurrently diagnosed. In fact, it is often apparent that their characteristic maladaptive patterns of interpersonal behaviour contribute to their misery. The same criteria for consultation and psychiatric admission apply here as in patients with adjustment disorder with depressed mood.

The term "dysthymia" has been coined so recently[3] that little data are available about results of treatment for this condition. The same supportive approach should be followed with patients with these conditions as has been referred to above,[5] though these patients will differ in that instead of having one precipitant or problem, they will have had a multitude of difficulties in their relationships and functioning. In patients who have few realistic opportunities for change in their life, especially if their depressive symptoms approach the severity required for a diagnosis of major depressive episode, an antidepressant may be considered in addition to the supportive psychotherapeutic approach. (Patients with major depressive episode who are correctly treated with antidepressants also deserve the same supportive psychotherapy, although the therapy may have to be limited or delayed if the patient's depressive symptoms are quite severe. Such patients are usually treated initially in a psychiatric inpatient unit.)

Interpretive Psychotherapy

Some patients with adjustment disorder with depressed mood or with dysthymia may not respond to the family physician's supportive approach. Other such patients may improve symptomatically, but the physician or patient may become aware of maladaptive patterns of behaviour or difficulties in relationships that do not change during the initial treatment. In these situations, a psychiatric consultation may be advisable. If a patient has refractory symptoms, the consultant may suggest another psychological treatment that may relieve these symptoms. The consultant may suggest that other patients, who have symptomatically improved with the supportive psychotherapy, can benefit further by a better understanding of the motivation for their repetitive maladaptive behaviour (in the case of dysthymia with a personality disorder) or of their sensitivity to the precipitant that resulted in a depressive reaction (in the case of adjustment disorder with depressed mood). Treatment can help such patients, when they are amenable, to remember difficulties in early relationships that predisposed them to their present reactions and, in distinguishing the present circumstances from the past, to learn to avoid repeating the problems in subsequent situations.

Patients likely to benefit from an interpretive psychotherapy are a minority of those with depressive symptoms, but they should be identified both because other treatments may not be as beneficial, and because the personality changes resulting from an interpretive therapy can protect the patient from further "depressions":

that is, interpretive psychotherapy is a form of secondary prevention. Qualities in a patient that favour this treatment include an interest in understanding the basis for one's problems ("motivation"); a relative tolerance for uncomfortable affects without impulsive or self-destructive behaviour; and "psychological mindedness", the willingness to see interpersonal difficulties as such, rather than considering their symptoms to be the result of a concrete problem requiring only submission to a medical treatment. Other positive factors include a relatively stable environment in contrast to family chaos or repeated crises, and a capacity for constructive work or sustained relationships.[6]

Conclusion: Avoiding "Misdiagnosis"

Ideally the term "depression" would be reserved for patients with antidepressant-responsive depressive illness. This usage is impractical because our colleagues, not to mention our patients, will continue to use "depression" to denote a symptom, a syndrome, or even a variation of normal mood. I suggest that family physicians should bear in mind the distinction between various types of "depression" and limit the prescription of antidepressants to those patients who are most likely to benefit from them. Appropriate psychotherapy without antidepressants should be prescribed to patients in whom antidepressants are not indicated, although it may be tempting to prescribe the antidepressant in the hope that it will help the patient, and the patient will often share this hope, or even demand the antidepressant.

It may support the physician in resisting an inappropriate request for antidepressants to know that in my experience of doing psychiatric consultations in a general hospital intensive care unit, by far the greater number of antidepressant overdoses are taken by patients with rather severe personality disorders in whom antidepressants were at best questionably indicated. These patients usually appeared, also, to be suffering from an adjustment disorder with depressed mood, or from dysthymia. Such patients, who may pressure the physician to prescribe a drug, or for whom the physician hopes to find a quick remedy because of the discomfort or trouble they cause him, often show by their effect on the physician that they are unlikely to have a depressive illness amenable to antidepressant treatment.

A patient with a depressive illness and reduced energy and self-esteem is unlikely to pressure the physician to do anything, and the physician is likely to feel compassion for such a patient. On the other hand, the discomfort that some patients with personality disorders can induce in us sometimes results in our prescribing a drug to relieve us of our discomfort with the patient, or to satisfy the patient's demands. It is nevertheless in the interest of such patients that we persevere in our attempts to help these patients find a constructive solution to their problems,[7,8] protecting them from the danger of overdose, and reserve antidepressant medications for those patients more likely to benefit from them. ■

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